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§15–146.

(a) In this section, "home– and community–based waiver services" includes services provided under the Living at Home Waiver, the Older Adults Waiver, and the Medical Day Care Waiver.

(b) At least 90 days prior to making any change to medical eligibility for Program long–term care services, including nursing facility services, home– and community–based waiver services, and other services that require a nursing facility level of care, the Department shall provide a report to:

(1) The Senate Finance Committee and the House Health and Government Operations Committee, in accordance with § 2–1257 of the State Government Article; and

(2) The Medicaid Advisory Committee.

(c) The report required under subsection (b) of this section shall include:

(1) The details of the intended change in medical eligibility;

(2) A description of how the intended change will affect current medical eligibility;

(3) The intended effective date of the change; and

(4) Whether the change will be pursued through departmental policy, by regulation, or by statute.

(d) The Department shall discuss any report submitted to the Medicaid Advisory Committee under subsection (b) of this section at a meeting of the Medicaid Advisory Committee.

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